BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

JOSEPH P. KOSSAR	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,055,359
MAREL FOOD SYSTEMS, INC.	)	
Respondent	)	
AND	)	
	)	
NEW HAMPSHIRE INSURANCE COMPANY	)	
Insurance Carrier	)	

ORDER

Respondent requested review of the May 29, 2012 Award by Administrative Law Judge (ALJ) Kenneth J. Hursh. The Board heard oral argument on October 9, 2012.

APPEARANCES

Timothy M. Alvarez, of Kansas City, Kansas, appeared for the claimant. Anton C. Andersen, of Kansas City, Kansas, appeared for respondent and its insurance carrier. E.L. Lee Kinch, of Wichita, Kansas, was appointed as a Board Member Pro Tem in this case due to the retirement of Board Member David A. Shufelt.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The Administrative Law Judge found that Dr. Carabetta's opinion was the most credible and awarded claimant a 45 percent permanent impairment to the left arm.

Respondent requests review of the nature and extent of claimant's impairment arguing that the Award should be modified to find claimant has a 10 percent impairment

to the left arm as Dr. Carabetta and Dr. Koprivica misapplied the rating standards of the AMA *Guides*. Respondent argues that the rating of Dr. Lingenfelter should have been adopted due to his use of range of motion and strength deficits in reaching his impairment opinion.

Claimant contends that the Award should be modified and the Board should average the ratings of Dr. Carabetta and Dr. Koprivica to find that claimant has a 49 percent impairment to the left arm.

FINDINGS OF FACT

Claimant has worked for respondent for five years. His job is to assist technicians in the daily support operations and the rebuild of meat-cutting machinery. On a daily basis, claimant performs general warehouse work and lifts a lot of machinery.

Claimant testified that on July 7, 2010, he was cleaning a machine postdemo when he slipped and broke his arm. Claimant testified that he had been walking in from of a machine and his feet flew out from under him, he went up 3 feet in the air and drove his left elbow into a concrete floor. He testified that the floor was wet from the chemicals and water he was using to clean the machine. Claimant was able to get up despite feeling a little stunned, but didn't realize how injured he was until he tried to open a door. At that point, he experienced severe pain in his left elbow. Claimant was taken to Overland Park Regional Medical Center and was admitted to the ER and respondent was notified.

At the ER, X-rays were taken and claimant was given pain medication. The x-rays displayed a severe fracture of the left elbow. Claimant was sent home and referred to orthopaedic surgeon Daniel Gurley, M.D., for a surgical consultation. On July 14, 2010, Dr. Gurley performed a distal ORIF of claimant's left humerus and a radial nerve transposition. Immediately following surgery, claimant had an aspiration event[1] and had to be transferred from the surgical center to the hospital. Claimant was in the hospital for two days and then had two months of follow-up visits, at-home convalescence and basic therapy to help him to refunction the nerves in his hands and fingers. Before therapy, claimant had an EMG, which indicated he had diminished nerve function in the area of the left median nerve and in the left radial nerve.

After treatment and therapy, claimant was able to return to work. He later received additional treatment with Dr. J. Douglas Cusick and had another EMG, which revealed a slight improvement in nerve function. No additional treatment was recommended and claimant continued to work. Claimant continues to experience symptoms of pain, numbness, tingling, loss of motor function, loss of strength and burning in his arm due to the July 2010 fall. Claimant testified that he continues to have symptoms in the upper part

[1] Claimant was bleeding from his stomach and aspirated blood into his lungs.

of his left arm all the way through to his wrist and fingers. He included pressure and locking up with loss of use as part of his symptoms.

Claimant testified that the numbness he has is in his hand and up three inches into his wrist. The numbness is constant, but the level varies depending on his use of the arm. He testified that the burning sensation he feels is from the hardware he has in his elbow and is present regularly and prominent in the elbow joint, but also goes midway up the arm between the elbow and the shoulder to the location of his scar. He really notices the burning and pain with lifting and constant repetitive motion. When his hand locks up it does so for five to eight minutes and claimant's pain level is then a seven or eight out of ten. His daily activities bring on this pain. Claimant described the pressure he feels as like hitting your thumb with a hammer and having pulsing pressure from the inside out. He feels this pressure predominately in the tips of his fingers and his thumb. Claimant is no longer able to straighten his arm completely above his head. Claimant has had range of motion limitations since his surgery.

On November 1, 2011, at the request of her attorney, claimant met with board certified emergency room physician P. Brent Koprivica, M.D., for an evaluation. Claimant's complaints included pain in the left elbow with use, loss of range of motion of the left elbow, inability to fully extend the left elbow, locking of the left thumb and hand at times, persistent numbness involving the radial and ulnar sensory distribution to the left hand and reduced endurance and strength while doing activities with resistence involving wrist dorsiflexion.

Dr. Koprivica examined claimant and found him to have decreased sensation in the left upper extremity that involved the ulnar and radial nerves and weakness of the radial innervated muscle groups on the left. Claimant's motor strength was a four out of five and he had atrophy of the left arm.

Dr. Koprivica opined that claimant's fall at work on July 7, 2010, represents the direct, proximate and prevailing factor in claimant's development of a comminuted supracondylar distal humeral fracture with intra-articular extension. He went on to opine that it is medically reasonable and a direct necessity of that injury that claimant underwent an open reduction and internal fixation, and it was necessary to transpose the ulnar nerve.[2]

Dr. Koprivica found claimant to be at maximum medical improvement in reference to the July 7, 2010 injury, but opined that it is more probably true than not that additional medical treatment will be necessary in the future. He also opined that a major concern at that point was the development of post-traumatic arthropathy involving the left elbow, based on the intra-articular fracture with potential need for intervention. He also discussed

[2] The surgery was performed by Dr. Gurley on July 14, 2010.

the potential of claimant needing to have the hardware in his elbow removed. He recommended that claimant's future medical treatment options be left open indefinitely.

Dr. Koprivica determined that, considering the complications of severe radial neuropathy, claimant has a 45 percent impairment to the left upper extremity, and a 10 percent impairment to the upper extremity due to transposition of the ulnar nerve at the elbow. He went on to find that as a result of loss of motion, claimant has an additional 3 percent impairment to the upper extremity. Dr. Koprivica then combined these ratings for a 52 percent impairment to the left upper extremity.[3]

Dr. Koprivica indicated that, even though claimant initially had motor loss which over time improved and then essentially went away, he still took into account claimant's past motor loss when he rated claimant.[4] He opined that if he had not known how claimant was injured or the severity of the injury and had only seen him on the day of the evaluation he would have rated claimant with a 15 or 16 percent impairment.

Dr. Koprivica testified that Dr. Gurley released claimant on March 7, 2011, and assigned a 40 percent left upper extremity functional impairment.[5] Claimant was evaluated by Dr. Pazell on July 5, 2011, and was assigned a 50 percent left upper extremity impairment.

Board certified physical medicine and rehabilitation specialist Vito J. Carabetta, M.D., initially met with claimant on August 30, 2010, for electrodiagnostic studies that were done at the request of Dr. Gurley. Dr. Carabetta met with claimant again on April 11, 2011, for evaluation at the request of Dr. Douglas Cusick, and again performed electrodiagnostic studies. Claimant was returned to regular duty in May 2011. Dr. Carabetta noted that claimant had shown some improvement between August 2010 and April 2011 when he conducted the electrodiagnostic studies on claimant.[6]

Dr. Carabetta met with claimant at the request of claimant's attorney for an examination on January 9, 2012. Claimant's chief complaint was residual pain and dysesthesias in the left upper extremity, constant aching pain in the posterior left elbow region and constant tingling sensation on the dorsum of the hand towards the little finger and thumb. Claimant also reported a feeling of pressure in the region. Claimant acknowledged that his overall complaints in those areas had improved. Claimant stated that, although his symptoms were about half of what they were at the start, he had not

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[3] Koprivica Depo. at 25-26, Ex. 2 at 12-13 (Nov. 1, 2011 report).

[4] Koprivica Depo. at 45.

[5] Koprivica Depo., Ex. 2 at 6 (Nov. 1, 2011 report).

[6] Carabetta Depo. at 32.

seen any real progress for about a half a year. This would indicate that claimant's improvement ended approximately one year after the accident, or sometime in the summer of 2011. Rest helps to ease claimant's complaints and cold temperatures aggravate his complaints.

Dr. Carabetta examined claimant and his impression was that claimant was status-post ORIF for left humerus fracture, status-post left ulnar nerve transposition and left radial neuropathy, partially improved. Dr. Carabetta opined that claimant was at maximum medical improvement and assigned the following impairment: for fracture of the humerus involving the articular surface at the elbow and some loss of mobility, 3 percent impairment of the left upper extremity; for the reduction in supination, 1 percent impairment; for injury to the left ulnar nerve, 10 percent impairment to the left upper extremity; for injury to the left radial nerve in the upper arm, 35 percent impairment of the left upper extremity. Combined these impairments result in a 45 percent impairment of the left upper extremity at the level of the elbow. Dr. Carabetta opined that, based on the information available, this impairment would be attributed to the injury on July 7, 2010.[7]

Dr. Carabetta testified that claimant had shown no improvement from April 2011 when he met with claimant for electrodiagnostic studies to January 9, 2012, when he met with claimant for the final examination.[8] He acknowledged that claimant had returned to the regular work duties he was performing before the accident.

Claimant met with orthopaedic surgeon[9], Dr. Erich Lingenfelter, on March 7, 2012, for an evaluation of his left arm at the request of respondent and its insurance carrier. Claimant reported complaints of numbness and tingling in the ulnar two digits, as well as dorsal hand numbness and tingling. Dr. Lingenfelter examined claimant and found him to have some mild loss of strength and residual loss of motion. He opined that claimant had suffered a distal humerus fracture with posttraumatic arthrofibrosis and loss of extension and flexion. Dr. Lingenfelter did not believe that claimant was at maximum medical improvement yet. But there was nothing more that could be done for the nerve because claimant had not resolved his range of motion deficits. Dr. Lingenfelter recommended an arthroscopic capsular release as a possible final treatment to achieve the best range of motion results. Dr. Lingenfelter determined that claimant has a 10 percent permanent partial disability to the left upper extremity as a result of the injury.

Dr. Lingenfelter testified that the first EMG differed from the second EMG in that, although claimant had subjectively complained of some left ulnar nerve symptoms, there was nothing on exam to suggest that there was any injury to the ulnar nerve. He noted that

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[7] Carabetta Depo., Cl. Ex. 6-7 at 4 (Dr. Carabetta's Jan. 7, 2012 IME report).

[8] Carabetta Depo. at 38.

[9] He specializes in elbows and shoulders.

the sensory distal latency for the left radial nerve remained unobtainable despite repeated efforts.

Dr. Lingenfelter testified that claimant was most bothered by the loss of motion and that is why the focus was on the diagnosis of posttraumatic arthrofibrosis. He testified that it wasn't really farfetched that the other doctors put claimant in a slightly different category than he did because they evaluated claimant at an earlier time than he.

Dr. Lingenfelter indicated that the best way to offer a rating opinion for claimant's type of injury is to go with the subjective complaints of the patient, the objective physical exam and then rate using the actual physical findings. That is how he came to the 10 percent impairment using the range of motion model.

Dr. Lingenfelter explained his method of rating upper extremities as follows:

> Q. What's your understanding of when it's appropriate to rate somebody for an upper extremity injury under the AMA Guides, 4th Edition?
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> A. I can tell you how I would do things. If it's a nerve injury, I think it's reasonable and appropriate to rate them at a timeframe where you think that the nerve will no longer recover. And if you compare the dates when he was examined -- the date of the injury -- can we go back to the date of the injury?
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> Q. July 7, 2010.
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> A. So right about close to my exam would be a closer time, in my opinion, to give a determination of what their true functional deficit is, because nerves can take a long time to recover. And clearly, if there's an earlier EMG that shows an injury and a follow-up EMG that shows improvement and an exam that shows very good strength -- some detectable difference but very good strength, considering this injury, I think that is the appropriate time.[10]

PRINCIPLES OF LAW AND ANALYSIS

In workers compensation litigation, it is the claimant's burden to prove his or her entitlement to benefits by a preponderance of the credible evidence.[11]

[10] Lingenfelter Depo. at 32.

[11] K.S.A. 44-501 and K.S.A. 44-508(g).

The burden of proof means the burden of a party to persuade the trier of fact by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.[12]

> If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act.[13]

K.S.A. 2000 Furse 44-510d(a)(13)(23) states:

> (13) For the loss of an arm, excluding the shoulder joint, shoulder girdle, shoulder musculature or any other shoulder structures, 210 weeks, and for the loss of an arm, including the shoulder joint, shoulder girdle, shoulder musculature or any other shoulder structures, 225 weeks.
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> . . .
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> (23) Loss of a scheduled member shall be based upon permanent impairment of function to the scheduled member as determined using the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

K.S.A. 44-510e defines functional impairment as:

> . . . the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

It is stipulated that claimant's injuries and resulting impairment are limited to his left upper extremity at the level of the arm. Therefore, the impairment is controlled by K.S.A. 2000 Furse 44-510d and is limited to his functional impairment. The impairment of function is to be determined with the use of the AMA *Guides*, 4th ed. As noted in this record, Dr. Lingenfelter utilized the AMA *Guides*, 5th ed. in reaching his impairment opinion. While he did testify that, with regard to table 16-34, the range of motion section, the tables in the 4th edition and the 5th edition are identical, he could not make that claim when discussing table 16-35, the strength deficit section of the *Guides*. He testified that, with regard to that table, the 4th edition may be different.

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[12] *In re Estate of Robinson*, 236 Kan. 431, 690 P.2d 1383 (1984).

[13] K.S.A. 44-501(a).

Additionally, in reviewing the tests performed by Dr. Carabetta, Dr. Lingenfelter determined that the EMG tests were not properly performed. The fact that Dr. Carabetta was unable to find a sensory response with the radial nerve was seen as a defect in the tests being performed. This criticism was countered by Dr. Carabetta's testimony regarding his long history of performing over 20,000 EMG tests in his career. Additionally, Dr. Lingenfelter performed no tests to support his contention that the EMGs performed by Dr. Carabetta simply missed the radial nerve. The Board finds the opinions of Dr. Carabetta to be more persuasive in that regard.

Claimant also presented the medical opinions of Dr. Koprivica regarding claimant's functional impairment. However, the *Guides* indicate that an impairment in this circumstance should be determined after the benefits of post surgery rehabilitation are realized. In this case, Dr. Koprivica did not consider claimant's rehabilitation when using the injury model of the AMA *Guides*. The Board finds the opinions of Dr. Koprivica to be unreliable for that reason. Again, the medical opinions of Dr. Carabetta are more persuasive. Claimant has satisfied his burden of proving that he suffered a 45 percent impairment of function to the left upper extremity at the level of the arm from the accident and resulting injuries on July 7, 2010. The Award of the ALJ is affirmed.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be affirmed.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Kenneth J. Hursh dated May 29, 2012, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of October, 2012.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

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Kenneth J. Hursh, Administrative Law Judge